

PACIFICARE LIFE ASSURANCE COMPANY

**5995 Plaza Drive,
Cypress, CA 90630-5028**

NAIC COMPANY CODE 84506

**MARKET CONDUCT
DESK EXAMINATION REPORT
as of December 31, 2006**

**PREPARED BY INDEPENDENT CONTRACTOR FOR THE
COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE**

PACIFICARE LIFE ASSURANCE COMPANY
5995 Plaza Drive
Cypress, Ca 90630-5028

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DESK EXAMINATION REPORT
as of
December 31, 2006

Prepared by
James T. Axman, CIE
Independent Contract Examiner

March 23, 2007

Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway Suite 850
Denver, Colorado 80202

Commissioner Morrison:

In accordance with §§ 10-1-203 and 10-3-1106, C.R.S., a market conduct examination of certain health insurance business practices of PacifiCare Life Assurance Company has been conducted.

The Company's underwriting and claims records were examined through a desk examination completed in Littleton, Colorado.

The desk examination covered the period from January 1, 2006 through December 31, 2006.

A report of the desk examination of PacifiCare Life Assurance Company is, herewith, respectfully submitted.

James T. Axman, CIE

Independent Market Conduct Examiner

**MARKET CONDUCT
DESK EXAMINATION REPORT
OF
PACIFICARE LIFE ASSURANCE COMPANY**

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COMPANY PROFILE

PacifiCare Life Assurance Company (hereinafter referred to as "PLAC" or Company) was incorporated on March 30, 1973 and has its principal executive office at 5995 Plaza Drive, Cypress, CA 90630. PLAC is a wholly-owned subsidiary of PacifiCare Health Plan Administrators, Inc., ("PHPA") formerly known as TakeCare Administrative Services Corporation, an Indiana corporation. FHP International Corporation ("FHP") merged into PacifiCare Operations, Inc. ("PACO") on March 31, 1999. PACO merged into PHPA, which in turn is a wholly-owned subsidiary of PacifiCare Health Systems, LLC ("PHS"), formerly known as PacifiCare Health Systems, Inc. PHS entered into an Amended and Restated Agreement and Plan of Reorganization, dated November 11, 1996 (the "Reorganization Agreement"), with FHP, whereby PHS acquired control of FHP and its subsidiaries including PLAC (the "Acquisition"). The Acquisition was completed on February 14, 1997 in accordance with the terms and conditions of the Reorganization Agreement. Effective October 27, 1998, PLAC changed its state of domicile from California to Colorado.

On December 20, 2005, pursuant to a Form A approved by the Colorado Division of Insurance, United Health Group Incorporated ("United"), through its wholly owned subsidiary, Point Acquisition LLC, acquired PLAC through the merger of PacifiCare Health Systems, Inc., a Delaware corporation into Point Acquisition LLC (survivor), a Delaware LLC, which changed its name to PacifiCare Health Systems, LLC. United is the ultimate controlling person of PLAC.

*As of December 31, 2005, the Company had reported premium in Colorado of \$156,475,000 for health insurance, representing a 2.13% market share of all accident and health insurance written in Colorado.

*Data as reported in the 2005 Colorado Insurance Industry Statistical Report.

PURPOSE AND SCOPE OF EXAMINATION

This market conduct desk examination report was prepared by an independent examiner contracting with the Colorado Division of Insurance (Division) for the purpose of auditing certain business practices of the Company. This procedure is in accordance with Colorado insurance law §10-1-204, C.R.S., which empowers the Commissioner to supplement the Division's resources to conduct market conduct examinations. The findings in this report, including all work products developed in the production of this report, are the sole property of the Division.

The purpose of the examination was to determine the Company's compliance with certain Colorado insurance laws. Specifically, this desk examination was an examination of the following:

- Certificate of coverage forms pertaining to prescription drug benefits in the Basic and Standard Health Benefit Plans offered in Colorado.
- The Company's handling of claims for services received from contracted (PPO) providers in which the maximum benefit was exhausted.
- The content, timeliness, and overall handling by the Company of cancellation notices and offers of conversion coverage for small groups whose coverage was terminated for reasons other than replacement by another carrier.

Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

This examination was governed by, and performed in accordance with, procedures developed by the National Association of Insurance Commissioners and the Division. In reviewing material for this report the examiner relied primarily on records and material maintained and/or submitted by the Company. The examination covered a twelve (12) month period of the Company's operations, from January 1, 2006 to December 31, 2006.

File sampling was based on a review of contract plans, cancellations, and claims files that were systematically selected using ACLTM software and computer data files provided by the Company. Sample sizes were chosen based on procedures developed by the National Association of Insurance Commissioners. Upon review of each file any concerns or discrepancies were noted on comment forms and delivered to the Company for review. Once the Company was advised of a finding contained in a comment form, the Company had the opportunity to respond. For each finding the Company was requested to agree, disagree or otherwise justify the Company's noted action. At the conclusion of each sample the Company was provided a summary of the findings for that sample. The examination report is a report by exception. Therefore, much of the material reviewed is not addressed in this written report. Reference to any practices, procedures, or files, which manifested no improprieties, was omitted.

An error tolerance level of plus or minus ten dollars (\$10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar (\$0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar (\$0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the

examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific Company practices does not constitute acceptance by the Division. Examination findings may result in administrative action by the Division.

EXAMINER'S METHODOLOGY

The examiner reviewed the Company's business practices to determine compliance with certain Colorado insurance laws. For this desk examination, special emphasis was given to the laws shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or Practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of Premiums – required term in contract.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-214, C.R.S.	Group Sickness and Accident Insurance.
Sections 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties and Timelines Concerning Division Inquiries and Document Requests
Insurance Regulation 4-2-18	Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions
Insurance Regulation 4-6-5	Concerning The Basic And Standard Health Benefit Plans

Contract Forms

The examiner reviewed the following contract forms, endorsements, and riders:

Form Number	Form Name
PCO199673-000_SG PPO	2006 PacifiCare Signature Options (PPO) Certificate Basic Health Benefit Plan
PCO279213-000	Amendment to the 2006 PacifiCare Life Assurance Company Certificates of Coverage
PCO223795-000	Colorado Health Plan Description Form – PPO Basic Health Benefit Plan of Colorado
PCO223093-000	Basic Health Benefit Plan (350P) PPO Schedule of Benefits
PCO312566-000	Cancer Screening Coverages (Colorado Health Plan Description Form Addendum)
PCO099489-001	Selected Benefit Descriptions (Colorado Health Plan Description Form Addendum) – (Pharmacy Plan Basic)
PCO099118-001	Outpatient Open Formulary (Three Tier with Generic Substitution) Prescription Drug Benefit
PCO199674-000	2006 PacifiCare Signature Options (PPO) Certificate Standard Health Benefit Plan
PCO223094-001	Standard Health Benefit Plan (351P) PPO Schedule of Benefits
PCO223796-000	Colorado Health Plan Description Form - PPO Standard Health Benefit Plan of Colorado
PCO093017-002	Cancer Screening Coverages (Colorado Health Plan Description Form Addendum)
PCO099124-000	Outpatient Prescription Drug Benefit Rider (Three Tier Formulary with Generic Substitution)
PCO100006-000	Selected Benefit Descriptions (Colorado Health Plan Description Form Addendum) - (Pharmacy Plan Standard)
PCO199756-000	Small Employer Group Health Insurance Policy

Cancellations

For the period under examination, a systematically selected sample of policies cancelled for non-payment of premium was taken as follows:

Review List	Population	Sample Size	Percentage to Population
Cancellations	739	50	7%

Claims Practices

For the period under examination, the examiner systematically selected the following sample of denied claims where specific discounts were applicable to cases where a maximum benefit had been reached:

Review List	Population	Sample Size	Percentage to Population
Claims denied where specific discounts were applicable in cases where a maximum benefit had been reached	27	27	100%

EXAMINATION REPORT SUMMARY

The examination resulted in five (5) issues in which the Company did not appear to be in compliance with Colorado insurance laws that govern health insurers operating in Colorado.

Contract Forms:

In the area of contract forms, one (1) compliance issue is addressed in this report:

- **Failure to include coverage for injectable medication under prescription drug benefits in the Basic and Standard Health Benefit Plans.**

Cancellations:

In the area of cancellations, two (2) compliance issues are addressed in this report:

- **Failure to timely and in a consistent manner terminate small group policies for nonpayment of premium.**
- **Failure to offer conversion coverage in a timely manner to members of groups whose policies are terminated for nonpayment of premium.**

Claims Practices:

In the area of claims practices, two (2) compliance issues are addressed in this report:

- **Failure, in some cases, to properly adjudicate participating provider claims.**
- **Failure to properly pay claims during the thirty-one (31) day grace period.**

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Division.

Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

PACIFICARE LIFE ASSURANCE COMPANY

PERTINENT FACTUAL FINDINGS

CONTRACT FORMS

Issue E1: Failure to include coverage for injectable medication under prescription drug benefits in the Basic and Standard Health Benefit Plans.

Colorado Insurance Regulation 4-6-5, Concerning The Basic And Standard Health Benefit Plans, promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2). C.R.S. ...
2. Standard Plan. The form and content of the standard health benefit plans, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".* [Emphasis added.]

JANUARY 1, 2006 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS

BASIC PERFERRED PROVIDER PLAN

PART B: SUMMARY OF BENEFITS

11. PRESCRIPTION DRUGS ⁹ (IN-NETWORK / OUT-OF-NETWORK)
 - \$20 copay preferred generic;
 - \$50 copay preferred brand name
 - \$70 copay non-preferred ^{9a}

Footnote: ⁹ Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado. Additionally, as noted above in footnote ³, prescription drug benefits are not subject to the deductible and the copays are not applied to the out-of-pocket maximums.

Footnote: ^{9a} Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".* [Emphasis added.]

JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY
PREFERRED PROVIDER AND HMO

STANDARD PREFERRED PROVIDER PLAN

PART B: SUMMARY OF BENEFITS

11. PRESCRIPTION DRUGS ⁹ (IN-NETWORK / OUT-OF-NETWORK)

\$10 copay preferred generic;

\$30 copay preferred brand name

\$50 copay non-preferred ^{9a}

Footnote: ⁹ Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits are not subject to the deductible and the copays are not applied to the out-of-pocket maximums.

Footnote: ^{9a} Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

In review of the Company's Colorado 2006 Signature Options (PPO) Certificate Basic Health Benefit Plan, form PCO199673-000, the following exclusion provision was noted on page 10:

IV. Exclusions and Limitations

Item 22. Drugs and Prescription Medication (Outpatient) - Outpatient drugs and prescription medications are not covered unless provided by a supplemental benefit rider. Refer to benefits, "Injectable Drugs" and "Infusion Therapy" for benefit coverage.

In the Company's Outpatient Open Formulary (Three-Tier With Generic Substitution) Prescription Drug Benefit rider form PCO099118-001, used by the Company with its Basic Health Benefit Plans, the following exclusion provision was noted:

Exclusions and Limitations

No benefits are payable for any of the following:

Item 25. Injectable Medications: Injectable Medications including but not limited to self-injectables, infusion therapy, allergy serum, immunizations agents and blood products are excluded. These medications may be covered under the Medical benefit and subject to applicable Deductibles or Coinsurance or Copayments. Injectable medications may be subject to the Company's Pre-Authorization requirements. Refer to the medical certificate for more information on coverage policies regarding injectable drugs.

Any benefit provided under the outpatient prescription drug benefit is not eligible as a Covered Expense under any other provision of the policy.

In review of the Company's Colorado 2006 Signature Options (PPO) Certificate Standard Health Benefit Plan form PCO199674-000, the following exclusion provision was noted on page 13:

IV. Exclusions and Limitations

Item 22. Drugs and Prescription Medication (Outpatient) - Outpatient drugs and prescription medications are not covered unless provided by a supplemental benefit rider. Refer to benefits, "Injectable Drugs" and "Infusion Therapy" for benefit coverage.

In the Company's Outpatient Prescription Drug Benefit Rider (Three-Tier Formulary with Generic Substitution), form PCO099124-000, used by the Company with its Standard Health Benefit Plans, the following exclusion provision was noted on page 4:

Exclusions and Limitations

No benefits are payable for any of the following:

Item 25. Injectable Medications: Injectable Medications including but not limited to self-injectables, infusion therapy, allergy serum, immunizations agents and blood products are excluded. These medications may be covered under the Medical benefit and subject to applicable Deductibles or Coinsurance or Copayments. Injectable medications may be subject to the Company's Pre-Authorization requirements. Refer to the medical certificate for more information on coverage policies regarding Injectable Drugs.

Any benefit provided under the outpatient prescription drug benefit is not eligible as a Covered Expense under any other provision of the policy.

The Company's basic and standard health benefit plans, in use during 2006, do not appear to be in compliance with Colorado insurance law in that they exclude coverage for injectable medication under prescription drug benefits. The Company may provide coverage for such medications under the medical benefits of the plans.

Colorado Insurance Regulation 4-6-5 requires that carriers "include the specific benefits and coverages outlined" in the tables of the regulation. Similarly, carriers may not reduce or exclude benefits and coverages which are outlined in the tables of the regulation. Pharmaceutical drugs are a specific benefit outlined in the tables of the regulation. Injectable drugs are pharmaceutical drugs and the regulation does not provide for a different level of coverage for this type of pharmaceutical drug; therefore, they must be covered in the same manner as other pharmaceutical drugs. If an injectable drug is not obtained through the pharmacy (including a mail-order pharmacy) then it would be subject to the level of coverage consistent with how it is supplied. If the injectable drug is obtained as part of an office visit, the office visit copay would apply. If the injectable drug is obtained as part of an outpatient hospital visit, then it would be included with the other services and supplies provided as part of the outpatient visit. Accordingly, the Company's excluding coverage for injectable drugs, or coverage of injectable drugs only through the "medical benefits" of the plan is not in compliance with the terms of the basic and standard health benefit plans as mandated by Colorado Insurance Regulation 4-6-5.

Recommendation # 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has amended its basic and standard health benefit plans to include coverage for injectable medication under the prescription drug benefits of such plans and implement necessary procedural changes in order to ensure compliance with Colorado insurance law.

CANCELLATIONS

Issue H1: Failure to timely and in a consistent manner terminate small group policies for nonpayment of premium.

Section 10-3-1104(1)(f)(II), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, *or in any other manner whatever*; [Emphasis added.]

Section 10-16-214, C.R.S., Group sickness and accident insurance, states in part:

- (3)(a) Except as provided for in subsection (2) of this section, all policies of group sickness and accident insurance providing coverage to persons residing in the state shall contain in substance the following provisions or provisions which, in the opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:
 - (I) A provision that the *policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder has given the insurer written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the policy* The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the coverage was in force during such grace period. [Emphasis added.]

Section 10-16-103.5, C.R.S., Payment of premiums - required term in contract, states in part:

- (1) Every contract between a carrier and a policyholder shall contain a provision that requires a policyholder to pay premiums:
 - (b) Through the date that the policyholder notifies the carrier that the policyholder no longer intends to maintain coverage for the group through the carrier.

During the examiner's review of the sample of small group policies terminated for nonpayment of premium and "Conversion Entitlement" letters, the examiner noted that the Company failed to properly terminate policies. The Company backdated the termination date of the policies to the last day for which premium had been received (prior to the grace period), thus effectively eliminating the grace period and the required time allowed for members to elect conversion coverage.

Letters notifying employees of their conversion right ("Conversion Entitlement" letters) were not sent to employees until long (at least thirty-six (36) days, and in some cases as many as seventy-one (71) days) after the Company terminated the group's coverage, thus compromising or eliminating the employees' conversion privilege.

Furthermore, as a result of the Company's action of retroactively terminating these groups' policies, employees may have incurred charges for services during the grace period for which they were eligible for benefits, but claims were not submitted. Finally, claims with dates of service during the grace period may be inappropriately denied.

Additionally, the Company's Colorado 2006 Signature Options (PPO) Certificate Basic Health Benefit Plan, form PCO199673-000, and Colorado 2006 Signature Options (PPO) Certificate Standard Health Benefit Plan, form PCO199674-000 state in part on pages 30 and 33 respectively:

Ending Coverage (Termination of Benefits)

Continuing coverage under this health benefit plan is subject to the terms and conditions of the Employer's Policy with the Company.

When the Policy between the Employer and the Company is terminated, all Covered Persons under the Policy become ineligible for coverage on the date of termination. *If the Policy is terminated by the Company for nonpayment of Premiums, coverage for all Covered Persons under the Policy will be terminated effective the last day for which Premiums were received.* According to the terms of the Policy, the Group Policyholder is responsible for notifying a Covered Person if and when the Policy is terminated for any reason, including the nonpayment of Premiums. The Company is not obligated to notify a Covered Person that he or she is no longer eligible or that the coverage has been terminated. [Emphasis added.]

And the Company's Small Employer Group Health Insurance Policy includes the following provisions regarding a Grace Period and policy termination on page 2:

GRACE PERIOD

After the first premium payment, the Company shall allow a Grace Period of 31 days following each Premium Due Date. *During the Grace Period, coverage under the Policy will remain in effect provided the Company receives the premium before the end of the Grace Period. If any premium is unpaid at the end of the Grace Period, the Policy will terminate in accordance with the Policy Termination section of the Policy.* [Emphasis added.]

POLICY TERMINATION

TERMINATION BY THE COMPANY. The company may terminate the Policy for any of the following reasons:

1. Nonpayment of the required premium.

The following chart illustrates the significance of error versus the population and sample examined:

Small Group Health Insurance Cancellations for Nonpayment of Premium

Population	Sample Size	Number of Exceptions	Percentage to Sample
739	50	50	100%

An examination of fifty (50) small group health insurance policies, representing 7% of all policies cancelled for nonpayment of premium handled by the Company during the examination period, showed fifty (50) exceptions (100% of the sample) wherein the Company failed to timely and in a consistent manner, terminate small group policies for failure to pay premium as required by Colorado insurance law.

To summarize, by failing to provide the grace period required by Colorado law, the Company:

1. May compromise individuals' right to guaranteed issuance of alternative group health coverage upon the occurrence of, for example, a change in family status;
2. May compromise individuals' right to conversion coverage;
3. May put individuals in the position of late applicants subject to a pre-existing condition limitation under a new policy or contract; and
4. May inappropriately deny claims incurred during the grace period.

Recommendation # 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, 10-16-214, and 10-16-103.5, C.R.S.. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has amended its cancellation procedures for nonpayment of premium and implemented necessary changes in order to ensure compliance with Colorado insurance law.

Issue H2: Failure to offer conversion coverage in a timely manner to members of groups whose policies are terminated for nonpayment of premium.

Section 10-16-102, C.R.S., Definitions, states in part:

(26) "Late enrollee" means an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual:

(III) Requests enrollment within thirty days after termination of the other creditable coverage; or

Section 10-16-108, C.R.S., Conversion and continuation privileges, states in part:

(1) Group sickness and accident insurance - conversion privileges.

(c)(I) A group policy delivered or issued for delivery in this state which provides hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense-incurred basis, but not including a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee, dependent, or member whose insurance under the group policy has been terminated for any reason other than discontinuance of the group policy in its entirety or with respect to an insured class or failure of the employee or member to pay any required contribution and who has been continuously insured under the group policy (and under any group policy providing similar benefits which it replaces) for at least three months *immediately prior to termination* is entitled to have issued by the insurer a policy of sickness and accident insurance, referred to in this paragraph (c) as the "converted policy", subject to the following conditions:

(A) Written application for the converted policy shall be made and the first premium paid to the insurer no later than thirty-one days after such termination.

(D) The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(E) The converted policy shall cover the employee or member and any dependents thereof who were covered by the group policy *on the date of termination of insurance*. ...

(d)(XV)(A) An employee or member who is entitled to make application for a converted policy pursuant to the provisions of paragraph (c) of this subsection (1) *shall be given written notice of the existence of the conversion privilege at least fifteen days prior to the*

expiration of the thirty-one-day conversion period established by the group policy. If the employee or member is not given notice of his conversion rights, the employee or member shall have an additional period within which to exercise such conversion privilege. This additional period shall expire fifteen days after the employee or member has been given such notice, but in no event shall the additional period be continued for more than sixty days after the expiration of the thirty-one-day period established by the group policy. [Emphasis added.]

(B) Written notice presented to the employee or member by the policyholder or mailed by the policyholder to the last-known address of the employee or member, as furnished to the policyholder, shall constitute the giving of notice for the purpose of this provision. If an employee or member is permitted an additional period for conversion, as provided in this subparagraph (XV), and if written application for the converted policy, accompanied by the initial premium, is made within the additional period, *the effective date of the converted policy shall be the day following the employee's or member's termination of insurance under the group policy. [Emphasis added].*

(4) Special provisions for small group health benefit plans.

(a) Effective January 1, 1995, each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection (4). *Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel. [Emphasis added.]*

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(c) Shall exclude coverage for late enrollees for the greater of twelve months or for no more than an eighteen-month-preexisting condition exclusion; ...

Section 10-16-214, C.R.S. Group sickness and accident insurance, states in part:

(3)(a) Except as provided for in subsection (2) of this section, all policies of group sickness and accident insurance providing coverage to persons residing in the state shall contain in substance the following provisions or provisions which, in the opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

- (I) A provision that the *policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder has given the insurer written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the policy.* The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the coverage was in force during such grace period. [Emphasis added.]

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

Section 5. RULES

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in federal regulations incorporated below.
3. The following sections of the federal regulations, adopted by the U.S. Department of Health and Human Services, are hereby incorporated by reference, and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S.

45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124b. These sections concern the method for counting creditable coverage; requirements for providing certificates of creditable coverage to those who were insured under group plans, including the form and content of the certificates; and requirements for providing certificates of creditable coverage to those who were insured under individual plans, including the form and content of the certificates.

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.
2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.
4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of “Significant break in coverage” found in Section 4.A. of this regulation.

The following chart illustrates the significance of error versus the population and sample examined:

Small Group Health Insurance Cancellations for Nonpayment of Premium

Population	Sample Size	Number of Exceptions	Percentage to Sample
739	50	50	100%

An examination of fifty (50) small group health insurance policies, representing 7% of all policies cancelled for nonpayment of premium, handled by the Company during the examination period, showed fifty (50) exceptions (100% of the sample) wherein the Company failed to offer conversion coverage in a timely manner upon termination of a group policy as required by Colorado insurance law. In all fifty (50) cases, the group’s coverage had been terminated retroactively back to the premium paid-through-date.

This retroactive termination process resulted in the loss of coverage of at least thirty-six (36) days, to as long as seventy-one (71) days prior to the date the “Conversion Entitlement” notice was sent to the members whose coverage had been terminated. This retroactive termination process and resulting delay in providing the “Conversion Entitlement” notices does not allow sufficient time for an insured to exercise his or her right to elect conversion (or other) coverage, and may result in the insured being considered a late enrollee under other coverage to which he or she may be entitled.

Recommendation # 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102, 10-16-108, 10-16-118, 10-16-214, C.R.S., and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has established procedures to ensure that all members of groups whose coverage is terminated for nonpayment of premium, are notified of the coverage termination and offered conversion coverage in a timely manner in order to ensure compliance with Colorado insurance law.

CLAIMS PRACTICES

Issue J1: Failure, in some cases, to properly adjudicate participating provider claims.

Section 10-3-1104(1)(f)(II), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, *or in any other manner whatever*. [Emphasis added]

For example, the Company's Colorado 2006 Signature Options (PPO) Certificate Basic Health Benefit Plan, form PCO199673-000, and Colorado 2006 Signature Options (PPO) Certificate Standard Health Benefit Plan, form PCO199674-000 under Section 5, Definitions, page 51, state in part:

Participating Provider – A Hospital, Physician, Facility or other health care Provider who has contracted with the Company or the Company's designated Preferred Provider Organization to provide services, treatment and supplies to a Covered Person at negotiated fees.

During the examiner's review of the claims sample provided by the Company, six (6) claims out of a total population of twenty-seven (27) claims appeared to be adjudicated incorrectly. Specifically, in the exception claims, the Company failed to apply the "insured's discount" to the claims where the maximum benefit allowed under the plan had been reached, thus increasing the patient's financial liability for payment to the provider.

As stated in the above definition, Participating Providers have contracted with the Company or the Company's designated Preferred Provider Organization to provide services, treatment and supplies to a covered person at "negotiated fees". "Participating Providers" do not become non-participating (or non-contracted) providers upon the member reaching a benefit maximum. Therefore, by the terms of the plan documents, the negotiated fee still applies and members' liability for expenses related to services received after a benefit maximum has been reached should be limited to the negotiated fee.

The following chart illustrates the significance of error versus the population and sample examined:

Small Group Health Insurance Claims Denied

Population	Sample Size	Number of Exceptions	Percentage to Sample
27	27	6	22%

An examination of twenty-seven (27) small group health insurance claims, representing 100% of all denied claims where specific discounts were applicable in cases where a maximum benefit had been reached, handled by the Company during the examination period, showed six (6) exceptions (22% of the sample) wherein the Company failed to adjudicate the claims properly as required by Colorado insurance law.

Recommendation # 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-3-1104, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has reviewed its claims adjudication procedure where a maximum benefit has been reached and has implemented the necessary procedural changes in order to ensure compliance with Colorado insurance law.

It is also recommended that the Company be required to complete a self-audit and pay any benefits due, including interest and penalties, for claims in which the Company failed to apply the “insured’s discount” when the maximum benefit allowed under the plan had been reached.

Issue J2: Failure to properly pay claims during the thirty-one (31) day grace period.

Section 10-16-214, C.R.S., Group sickness and accident insurance, states in part:

(3)(a) Except as provided for in subsection (2) of this section, all policies of group sickness and accident insurance providing coverage to persons residing in the state shall contain in substance the following provisions or provisions which, in the opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

(I) A provision that *the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force unless the policyholder has given the insurer written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the coverage was in force during such grace period.* [Emphasis added.]

Section 10-16-704, C.R.S., Network adequacy - rules - legislative declaration – repeal, states in part:

(4.5)(h) In circumstances where a carrier determines that a premium has not been received during a grace period required by section 10-16-214(3) for a group policy, the carrier may report to the provider that the carrier is not required to pay for health care services rendered to an enrollee during a time in which the carrier can demonstrate that the policyholder has secured coverage with another carrier.

(j) A carrier *shall not retroactively adjust a claim based on eligibility if the provision of benefits is a required policy provision pursuant to section 10-16-202 (4) or section 10-16-214 (3).* [Emphasis added]

During the examination, the Company indicated that its claims handling practice is to attempt to recoup money from providers on claims that were paid during the grace period and for which premium was not received from the group policyholder. This practice appears to conflict with § 10-16-214(3)(a)(I), C.R.S., which provides that coverage stays “in force” during the grace period. Accordingly, unless an exception applies, retroactive adjustments or recoupments should not be made to claims incurred during the grace period.

An exception to the prohibition against retroactive adjustments or recoupments is found in § 10-16-704(4.5)(h), C.R.S., in circumstances where a carrier determines that a premium has not been received during the mandated grace period and can demonstrate that the policyholder has secured coverage with another carrier.

Recommendation # 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-214, and 10-16-704, C.R.S. In the event the Company is unable to provide such documentation, it should be required to provide evidence to the Division that it has reviewed its claims procedures concerning claims incurred during the thirty-one (31) day grace period and implemented necessary procedural changes in order to ensure compliance with Colorado insurance law.

It is also recommended that the Company be required to complete a self-audit and pay any benefits due, including interest and penalties, for claims that were incurred during members' group's grace periods in cases where group policies were retroactively terminated for nonpayment of premium. Also, as a result of the Company retroactively terminating group health policies for nonpayment of premium, employees may have incurred charges for services that may have been eligible for reimbursement, but not submitted. Therefore, the Company should waive any filing requirements for claims that may not have been timely submitted as a result of retroactively terminating coverage that should have remained in effect during the grace period.

Summary of Issues and Recommendations

PACIFICARE LIFE ASSURANCE COMPANY

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Independent market conduct examiner
James T. Axman, CIE
participated in this examination and in the preparation of this report.